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SPA PCP Treatment & Referral Guidelines
Podiatry

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I. Routine Foot Care

Medicare's Definition of Routine Foot Care

Medicare defines "routine foot care" as:

"any service performed in the absence of localized illness, injury or symptoms involving the foot."

Routine foot care services include:

- A) The cutting or removal of corns or calluses

- B) The trimming of nails, including mycotic

Medicare **does not cover routine foot care** services **unless** certain requirements are met. Those requirements are:

- A) A medical doctor is treating you for a medical condition affecting your legs or feet, and

- B) The condition requires that a podiatrist or a doctor of medicine or osteopathy perform the routine foot care. Diabetes, peripheral vascular diseases, pain associated with mycotic nails that limits ambulation, peripheral neuropathy, and chronic renal disease, are a few examples

Medicare Coverage of Routine Foot Care Services (Medicare Part B)

Medicare **will cover "routine" foot care services** when:

- A) They are an "integral and necessary part" of an otherwise covered Medicare service (i.e. As part of the diagnosis or treatment of ulcers, wounds or infections) then the foot care service is covered

- B) Scrupulous foot care by a professional is necessary due to the "presence of a systemic condition" such as metabolic, neurologic or peripheral vascular disease resulting in severe circulatory embarrassment or areas of diminished sensation in the individual's legs or feet

Medicare limits coverage of combined nail procedures listed in this section to one visit per patient per 60-day period. In other words, you may cut a corn or callous and trim or debride nails within a 60-day period if conditions A) or B) listed above are met. However, duplication of services within the 60-day period is not allowed

II. Preventive Foot Care in Diabetes Mellitus

- A) Low Risk Patients

No history of PVD or Neuropathy (Neurological changes)

Recommendation: Semi- Annual assessment by PCP

Evaluate

- a) Pedal pulses
- b) Dorsal foot and digital hair growth
- c) Capillary filling time
- d) Any dystrophic nail or skin changes
- e) Monofilament testing

Recommend to Patients:

- a) Preventive care measures with good skin and nail care and appropriate footwear
- b) Refer unmanageable painful nails, corns, calluses, and other escrescences or lesions to Podiatrist for evaluation and treatment
- c) Low risk and high risk of peripheral neuropathy should be referred

B) High Risk Patients

- a) History of PVD, diabetes, or other metabolic disorders
 - Leg and foot cramps, resting and night pain
 - Intermittent Claudication
 - Dystrophic skin and nail changes with painful corns, calluses, and toenails

Recommendations:

- 1) Assessment of patient over three months
- 2) Reinforce self-assessment by patient daily

- b) History of advanced PVD with marked Vascular Compromise
 - History of prior amputation or surgical debridement
 - History of prior ulcerations or Osteomyelitis
 - History of advanced Neuropathy

Recommendations:

Refer to Podiatrist for regular (every two months) preventive care and assessment

Good podiatraic maintenance care will reduce the risk of further infections, ulcerations, surgery and hospitalizations

III. Symptomatic Hammertoe (735.4, 755.66)

A) Definitions

Hammertoes may occur in the sagittal, transverse, or frontal planes or a combination thereof. They may be associated with painful hyperkeratotic lesions (corns) overlying, adjacent to, any or all of the interphalangeal joints or on the distal-most aspect of the affected digit. Adventitious bursa(e) may develop between the lesion and the underlying bone. The deformity may be flexible (reducible), semi rigid (partially reducible), or rigid (nonreducible) in nature. There may also be additional deformities at the metatarsal phalangeal joints

B) Symptoms

Pain, corns, bursitis, ulceration at pressure points, or infection. A combination of these symptoms may be present

C) Workup

Identify the pathology. Family history of problem how quickly has the deformity progressed, type of footwear being worn, how long problem has been present; determine the flexibility or lack of flexibility in the digit: X-rays are generally not needed at the initial workup unless infection is present

D) Treatment

Treat the pathology that is present. The goal of treatment is to reduce symptoms so patient can return to normal activities

- a) Discuss footwear. Hosiery must fit. Shoes must be fit properly. They must be long enough and also the proper width. (Wide shoes alone do not help. They allow the foot to slip further into the toe box resulting in more pressure on the toes.) The toe box should be deep enough so as not to compress the toes
- b) If proficient, reduce the painful lesion (corn) with a sharp blade. **Do not prescribe the OTC corn medications (because they are acids and cause burns and/or infections)!**
- c) NSAID's for non-infected inflammations
- d) Steroid injections for resistant bursitis or capsulitis
- e) Appropriate antibiotics for infections

E) Referral

If treatment does not help or if problem recurs, refer the patient

- a) Weight bearing x-rays of the feet should be ordered and the patient must bring them for the appointment (if available)
- b) Have patient bring the shoes they wear for work and those they wear for other activities

IV. Heel Pain Syndrome

A) Includes

Plantar heel pain, plantar fasciitis, heel spurs, posterior heel pain, apophysitis (ages 10-14)

B) Hallmarks

Pain after rest – especially first steps out of bed in AM, worse again after activity, better with supportive shoes

C) Treatment

Plantar Heel Pain; Plantar fasciitis, Heel Spurs, Apophysitis (kids): Strictly a support issue, so more supportive shoes – quality jogging shoes ideal. Avoid bare foot walking or flat sandals. At least shoe with firm heel counter (posterior-most

portion of shoe), which connotes better shoe construction. Use good quality OTC arch support like Superfeet, Birkenstock brand, ¼” heel lift, etc. NSAIDs. May try cortisone shot once

Posterior Heel Pain: Gastro-soleus stretching, ¼” heel lift temporarily, NSAIDs

What Not To Do:

- a) Tendency to want to cushion the heel usually not helpful over time, x-rays initially **not helpful**, do not repeat cortisone shot

When to Refer:

No improvement after 4-6 weeks

V Ingrown Toenail, Onychia, Paronychia (703.0, 688.11)

A) Characteristics

- a) Pain, tenderness, swelling and ingrown at the borders
- b) May lead to infection with drainage, malodor, abscess, erytherma, and pyogenic granuloma at the borders
- c) Chronic infection of the toenail may, in some cases, lead to osteomyelitis

B) Causes

- a) Improperly cut toenails
- b) Poor fitting shoes
- c) Trauma, sports injury
- d) Hyperhidrosis
- e) Obesity
- f) Biomechanical disturbances of the feet in relation to the lower extremities

C) Treatment

- a) Oral antibiotics may treat the infection but will not treat the ingrown toenail problem
- b) Partial nail avulsion of the affected borders for first time occurrence may be needed, especially in cases with infection
- c) Partial matricectomy of the offended border(s) will be necessary for chronic infected and ingrown toenail
- d) Referral is appropriate especially in chronic cases and in patients with diabetes mellitus, poor vasculature, neuropathy and other at risk conditions

VI Hallux Valgus (Bunion 735.0)

A) Definitions

Includes painful prominence of the first metatarsal head with adduction of the hallux at the first metatarsophalangeal joint

B) Symptoms

- a) Pain at the first metatarsophalangeal joint
 - b) Limitation of range of motion at the first metatarsophalangeal joint
 - c) Deformity of the first metatarsophalangeal joint including prominence of the metatarsal head or deviation of the great toe
- C) Treatment
- a) Comfortable shoe gear (wider at forefoot)
 - b) NSAIDs as appropriate
 - c) OTC arch support
- D) Referral
- a) When shoe therapy and NSAID therapy has failed, and patient understands that next options are either orthotics, or surgical intervention
 - b) Most significant feature requiring aggressive therapy is pain
- E) Referral should include
- a) X-rays should be sent with the patient to the podiatry appointment and should include AP/Bilateral weight bearing films

VII Mycotic Nail (110.1)

- A) Diagnosis
Clinical appearance, KOH will confirm findings. Differential diagnosis includes traumatic nail hypotrophy, psoriasis, and traumatic hypertrophy
- B) Treatment
Debridement and careful manicuring is all that is necessary. Oral antifungal agents should be used with caution
- C) Referral
Persistent painful nails, secondary bacterial infection, diabetes mellitus, with vascular compromise or peripheral neuropathy

VIII Plantar Verruca (CPT 078.19) (Wart, Papilloma)

- A) Diagnosis
Clinical Signs
- a) Debridement of kerotosis may reveal pinpoint bleeding from lesion and absence of skin lines through lesion
- B) Differential Diagnosis
- a) Mechanical hyperkeratosis, intractable focal planter keratosis, inclusion cyst, synovial cyst
- C) Treatment
Topical treatment with 40% salicylic acid under occlusion may be tried

- D) Referral
Painful plantar Verruca non responsive

IX. Fracture Management

Non-displaced digital fractures do not need to be referred

- A) Treatment
Tape splinting with or without padding, and use of crutches

All other fractures refer with x-rays. Any question as to other emergency treatment, call the podiatrist

APPROVAL:


SPA Medical Director

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